MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8830

CERTIFICATE OF DEATH

8842

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 13th & Boardwalk

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY: Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Miami
d. STREET ADDRESS: 276 NW 6th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew; Middle: (None); Last: Askew

4. DATE OF DEATH: Month: August; Day: 25; Year: 1956

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Approx 1900

9. AGE (If years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bellman

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Washington County Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Archie Askew

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 262-05220

17. INFORMANT: Robert Archie Adams — Address: 1702 Calhoun St Jacksonville Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arterio-sclerotic CVD — 5 years
DUE TO (c):

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 8, 1956, to Aug 25, 1956, that I last saw the deceased alive on Aug 8, 1956, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F J Townsend, Jr. M.D.
ADDRESS (Street, city or town, state): Ocean City, Md.
DATE SIGNED: Aug 25, 56
PHYSICIAN'S NAME (Type): F. J. Townsend Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 8-29-'56
22c. NAME OF CEMETERY OR CREMATORY: Church Cemetery
22d. LOCATION (City, town, or county) (State): Dennis Washington Co. Ga

23. FUNERAL DIRECTOR'S SIGNATURE: J. F. Stewart
ADDRESS: Funeral Home, Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: AUG 30 1956
24b. REGISTRAR'S SIGNATURE: Helen L. Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

CERTIFICATE OF DEATH

68831 356
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin (rural)
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jeffery Middle: Andrew Last: Bratten

4. DATE OF DEATH: Month: 8 Day: 19 Year: 19 56

5. SEX: Male

6. COLOR OR RACE: A.A.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8 15 56

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: 4
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): USA Mary land

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Bratten

14. MOTHER'S MAIDEN NAME: Ethel Purnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: William H. Bratten, Berlin, Md. Rt # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs

DUE TO

763.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/15, 19 56, to 8/19, 19 56, that I last saw the deceased alive on 8/18, 19 56, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leroy U. Sudy Jr M.D. ADDRESS (Street, city or town, state): Berlin Md DATE SIGNED: 8/21/56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-20-56

22c. NAME OF CEMETERY OR CREMATORY: Davis Cemetery

22d. LOCATION (City, town, or county) (State): Berlin, Md Rt #2

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Stewart Funeral Home, Salisbury, Md

24a. REC'D BY REGISTRAR DATE: AUG 22 1956

24b. REGISTRAR'S SIGNATURE: Helen F. Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2000276 XV6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8841 (8832)

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 40 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
d. STREET ADDRESS: BALTIMORE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: SADIE; Middle:; Last: CAREY

4. DATE OF DEATH: Month: AUG. Day: 4 Year: 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 17, 1897

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL CROPPER

14. MOTHER'S MAIDEN NAME: AMELIA LYNCH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MR. CLARENCE CAREY, Address: OCEAN CITY, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion ACUTE — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
DUE TO (b): ARTERIO Sclerotic CVD — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatoid Arthritis Cystic Disease of Kidneys

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN, 1947, to AUG 4, 1956, that I last saw the deceased alive on AUG 4, 1956, and that death occurred at 11 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F J Townsend Jr M.D. — ADDRESS (Street, city or town, state): Ocean City, Md — DATE SIGNED: Aug 6 56

PHYSICIAN'S NAME (Type): F. J. TOWNSEND Jr M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/7/56
22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
22d. LOCATION (City, town, or county) (State): BERLIN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: 8/9/56

24b. REGISTRAR'S SIGNATURE: Helen F Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8845

CERTIFICATE OF DEATH

Reg. Dist. No. 188953

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton
c. LENGTH OF STAY IN 16 94 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Md — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle Parker Last Cherrix

4. DATE OF DEATH Month Aug Day 9 Year 1956

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct. 13-1861

9. AGE (In years last birthday) 94 9 29

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY Own Farm

11. BIRTHPLACE (State or foreign country) Stockton, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Cherrix

14. MOTHER'S MAIDEN NAME Minnie Dukes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Mrs John E Cherrix, Stockton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 5 weeks
490.X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 4, 1956, to Aug. 9, 1956, that I last saw the deceased alive on Aug. 8, 1956, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas L. Jones, M.D. — ADDRESS (Street, city or town, state) Snow Hill, Md. — DATE SIGNED 8/10/56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF Aug 12/56 — 22c. NAME OF CEMETERY OR CREMATORY Methodist — 22d. LOCATION (City, town, or county) Stockton (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Elay E Timmons — ADDRESS Snow Hill, Md

24a. REC'D BY REGISTRAR DATE AUG 13 1956 — 24b. REGISTRAR'S SIGNATURE Elwyn Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8845 **CERTIFICATE OF DEATH** 08834

Reg. Dist. No. 351

1. PLACE OF DEATH

COUNTY Worcester — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill Rudd #1

LENGTH OF STAY (in this place) 68 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill Rudd #1

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) George (Middle) T. (Last) Dale

4. DATE OF DEATH (Month) Aug. (Day) 29 (Year) 19 56

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored	Married	Sept. 10/1887	68/11/19 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor		Snow Hill, Md	

13. FATHER'S NAME Harry Dale

14. MOTHER'S MAIDEN NAME Amy Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		None	Mrs Sattie M. Dale, Snow Hill, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1 IMMEDIATE CAUSE (A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 2.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/22, 1956, to 8/29, 1956, that I last saw the deceased alive on 8/28, 1956, and that death occurred at 1:00 A.M, from the causes and on the date stated above.

SIGNATURE Thomas L. Jones, MD — **ADDRESS** (Street, city, town, state) Snow Hill, Md. — **DATE SIGNED** 8/30/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 1 56	Mt Wesley	Snow Hill, Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
AUG 31 1956	Elwyn Cooper	Elbert O. Dennis	Snow Hill, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8847 **CERTIFICATE OF DEATH** 08835

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: xxx

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whaleyville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First PETER — Middle A. — Last DALE

4. DATE OF DEATH: Month Aug. — Day 12 — Year 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan, 1 1888

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Dale

14. MOTHER'S MAIDEN NAME: Ki tty Whaley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): X
(If yes, give war or dates of service): X

16. SOCIAL SECURITY NO.: x

17. INFORMANT: Hayward Dale — Address: Whaleyville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chr Myocarditis - acute attack — INTERVAL BETWEEN ONSET AND DEATH
592X
DUE TO
(b): Chr Nephritis I — 3mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Hy pertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from May, 1956, to Aug 12, 1956, that I last saw the deceased alive on Aug 11, 1956, and that death occurred at 6.30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas R. Law M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 8 13 56

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 15, 1956

22c. NAME OF CEMETERY OR CREMATORY: Pullets Chapel

22d. LOCATION (City, town, or county) (State): Whaleyville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville Del

24a. REC'D BY REGISTRAR DATE: AUG 17 1956

24b. REGISTRAR'S SIGNATURE: Helen F. Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8848

CERTIFICATE OF DEATH

08836
Reg. Dist. No. 351

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS 411 Tingle St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Laura Middle Ginn Last
4. DATE OF DEATH Month Aug. Day 15 Year 1956

5. SEX F.
6. COLOR OR RACE C.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH March 10, 1878
9. AGE (In years last birthday) 78 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Raley Ginn
14. MOTHER'S MAIDEN NAME Sarah Selby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Horace Ginn Address 411 Tingle St. Snowhill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular
DUE TO
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
5 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19____, to 8/15/56, 19____, that I last saw the deceased alive on 8/14/56, 19____, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Paul Cohen M.D.
ADDRESS (Street, city or town, state) Snow Hill Md.
DATE SIGNED 8/16/56
PHYSICIAN'S NAME (Type) Dr. Paul Cohen

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-19-56
22c. NAME OF CEMETERY OR CREMATORY Georgetown
22d. LOCATION (City, town, or county) (State) Pocomoke Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton ADDRESS New Church, Va.
24a. REC'D BY REGISTRAR DATE Aug 15, 56
24b. REGISTRAR'S SIGNATURE Hugh E. Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68837
Reg. Dist. No. 355

8849

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Berlin
c. LENGTH OF STAY IN 1b 3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 113

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Georgia b. COUNTY Thomas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAVO (Rural) 49x3
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle H. Last Graham
4. DATE OF DEATH Month Aug Day 27 Year 1956

5. SEX M
6. COLOR OR RACE NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1906
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Balston Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dan Graham
14. MOTHER'S MAIDEN NAME Nita Dunton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Address James Graham Pavo Georgia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation with Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 20 min.
DUE TO (b) Arteriosclerotic CVD — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE F. J. Townsend Jr. M.D.
EXAMINER'S NAME (Type) F. J. TOWNSEND JR.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED Aug 27, 56.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-30-56
22c. NAME OF CEMETERY OR CREMATORY Houston Cemetery
22d. LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. F. Stewart Funeral Home, Salisbury, Md.
24a. REC'D BY REGISTRAR DATE AUG 31 1956
24b. REGISTRAR'S SIGNATURE Helen F. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8859 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 202 8-30-56 et

B8838

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belmont Hotel

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47x-3
d. STREET ADDRESS: 6617 ADAMS ST. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle FRANCIS Last HEALY

4. DATE OF DEATH: Month August Day 23 Year 1956

5. SEX: M.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 31, 1912

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS HEALY

14. MOTHER'S MAIDEN NAME: HELEN FERRER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: MRS. ELIZABETH LEFFSON Address 6505 44th Ave. College Park MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Heart Disease 420.1 — Interval between onset and death: 4-5 yrs

DUE TO (b): Acute Coronary Thrombosis — 6-8 hours

DUE TO (c): Coronary Insufficiency & Insufficiency — 4-5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Kyphoscoliosis sec to Poliomyelitis in childhood —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A. Robbins M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 8/23/56

EXAMINER'S NAME (Type): HERMAN A. ROBBINS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 8/23/56

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM.

22d. LOCATION (City, town, or county) (State): WASHINGTON D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas A. Burbage — ADDRESS: Berlin Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 1956

24b. REGISTRAR'S SIGNATURE: Helen L. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8851

CERTIFICATE OF DEATH

8839

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: ST. MARTINS (RURAL)
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First LIDA — Middle CORDELIA — Last HOLLAND

4. DATE OF DEATH: Month AUG — Day — Year 1956

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: APRIL 18, 1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN, MD (RFD

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN V. DENNIS

14. MOTHER'S MAIDEN NAME: HETTY CATHGRING TIMMONS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MRS. BESSIE HOLLAND, BERLIN, MD USA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: ?

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocarditis — ?

DUE TO (c): Hypertension — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Month, Day, Year: None — Hour: — p. m.

20d. INJURY OCCURRED While at work ☐ Not at work ☐: None

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 15, 1956, to Aug 1, 1956, that I last saw the deceased alive on July 30, 1956, and that death occurred at 2:00 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford E. Schott M.D. — ADDRESS (Street, city or town, state): Berlin Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT M.D. BERLIN MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/4/56

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Anna A. Burbage. Berlin Md

24a. REC'D BY REGISTRAR DATE: 8/5/56

24b. REGISTRAR'S SIGNATURE: Helen F Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CLIFFORD E. SCHOTT M.D. BERLIN MD

RECEIVED

AUG 7 1956

BUREAU V. S.

8852

09805

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Worcester — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Berlin

LENGTH OF STAY (In this place): 3 WEEKS

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Pa — COUNTY Lancaster

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Robrestown Pa.

STREET ADDRESS (If rural, give location): 75 x 3

3. NAME OF DECEASED: (Type or Print) (First) Eugene (Middle) Kang (Last) Horst

4. DATE OF DEATH (Month) August (Day) 1 (Year) 19 56

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	MARRIED	Oct. 2, 1932	23 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Silo Builder	Silo Erection	Lancaster Co. Pa	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William K. Horst	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes		Mrs. E. K. Horst, Quarryville Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

902.5

Immediate cause (a) Fracture of Base of Skull — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 10 to 15 min.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.. INJURY: Building Site	21c. (City or town) Berlin	(County) Worcester Co.	(State) Md

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☑ Not while at work ☐	21f. HOW DID INJURY OCCUR?
Aug. 1 1956 3:45 P.M.	1	Fell & backfold.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Herman C. Rabbitt M. D.

M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑

DATE SIGNED: 8/1/56

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/4/56		Quarryville	Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/2/56	Helen F. Hayward	Irma A. Bunting	Berlin Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8853

CERTIFICATE OF DEATH

(8841) Reg. Dist. No. 357

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STOCKTON
d. STREET ADDRESS Stockton, Md.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First SAMUEL Middle MASON Last
4. DATE OF DEATH Month August Day 13 Year 1956

5. SEX MALE
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Feb. 6, 1886
9. AGE (In years last birthday) 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY FARM
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BENJAMIN MASON
14. MOTHER'S MAIDEN NAME Ester ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address Philmore Mason - Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease
443X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 7, 19 56, to Aug. 13, 19 56, that I last saw the deceased alive on Aug. 1, 19 56, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas L. Jones, M.D. M.D. ADDRESS (Street, city or town, state) 312 E. Market St. Snow Hill, Md. DATE SIGNED 8/12/56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 8-16-56
22c. NAME OF CEMETERY OR CREMATORY Mt. HOPE
22d. LOCATION (City, town, or county) (State) POCOMOKE MD.

23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Hancock ADDRESS New Church, Va.
24a. REC'D BY REGISTRAR DATE Aug 16, 56
24b. REGISTRAR'S SIGNATURE Elwyn E. Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8841-55

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elm St & Dual Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Florida — b. COUNTY Dade
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Homestead
d. STREET ADDRESS Route 1 P.O Box 380
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle Richard — Last Melvin

4. DATE OF DEATH: Month Aug — Day 1 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24 1929

9. AGE (In years last birthday): 27 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Transport

11. BIRTHPLACE (State or foreign country): Chincoteague, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Carpenter Melvin

14. MOTHER'S MAIDEN NAME: Lucy Florence Coons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) AIR FORCE 1945-46

16. SOCIAL SECURITY NO. 181 22 3712

17. INFORMANT: Paul Melvin — Address: Ocean City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound Head — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) Playing Russian Roulette

20c. TIME OF INJURY: Hour 12:40 p. m. — Month, Day, Year July 31 1956

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Store

20f. (City or town) RURAL Ocean City — (County) Worcester — (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE F J Townsend Jr M.D.
EXAMINER'S NAME (Type) F J TOWNSEND JR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED Aug 3, 56.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8 6 1956
22c. NAME OF CEMETERY OR CREMATORY: SILVERBROOKE CREM
22d. LOCATION (City, town, or county): WILMINGTON (State) DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: Amon A. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE 8/5/56

24b. REGISTRAR'S SIGNATURE: Helen F Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18842

Reg. Dist. No. 355

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
   a. COUNTY: Worchester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Berlin
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): South Point (Bay)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
   d. STREET ADDRESS: C/o Postmaster
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FLOYD — Middle NORMAN — Last POWELL

4. DATE OF DEATH: Month Aug. — Day 23 — Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 13, 1926

9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Hebron, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James W. Powell

14. MOTHER'S MAIDEN NAME: Virgie Mae Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 218-20-7830

17. INFORMANT — Address: Mr. James W. Powell (Father) Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffication due to Drowning — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

929.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [✓], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [✓], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Herman A. Robbins M.D. — CHIEF MEDICAL EXAMINER [ ] — ASSISTANT MEDICAL EXAMINER [✓] — DEPUTY MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): HERMAN A. A. ROBBINS — DATE SIGNED: 8/24/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 26, 1956

22c. NAME OF CEMETERY OR CREMATORY: Parsonsk Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR — DATE: 8/28/56

24b. REGISTRAR'S SIGNATURE: Helen Hayward

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

8840 **CERTIFICATE OF DEATH**

Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peacock Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: 109 Willow St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLES Middle HERBERT Last SMITH, Jr.

4. DATE OF DEATH: Month August Day 19 Year 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 10, 1897

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Appliances

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Smith, Sr.

14. MOTHER'S MAIDEN NAME: Marie E. Drew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 218-05-1333

17. INFORMANT: Florence E. Smith, Pocomoke, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION
DUE TO
(b): LUETIC CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 30 YEARS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

023X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 1, 19 56, to AUGUST 19, 19 56, that I last saw the deceased alive on AUGUST 19, 19 56, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. Stanford Hamilton M.D.
ADDRESS (Street, city or town, state): POCOMOKE CITY MD
DATE SIGNED: 8-20-56

PHYSICIAN'S NAME (Type): C. Stanford Hamilton Pocomoke, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/22/56
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Presbyterian
22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry F. Watson
ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: AUG 22 1956
24b. REGISTRAR'S SIGNATURE: Anne Hute

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

8856 — 68844 — Reg. Dist. No. 353

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: LIBERTYTOWN
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First RALPH — Middle — Last TRIMBLE

4. DATE OF DEATH: Month AUG. — Day 7 — Year 1956

5. SEX: M. — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: JUNE 13, 1887 — 9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER — 10b. KIND OF BUSINESS OR INDUSTRY: SELFEMPLOYED — 11. BIRTHPLACE (State or foreign country): BARBOUR Co. W. VA — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN TRIMBLE — 14. MOTHER'S MAIDEN NAME: EUDORA McCOY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: [redacted] — 17. INFORMANT: Address: MRS. LAURA TRIMBLE BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial attack — INTERVAL BETWEEN ONSET AND DEATH:
422.2
DUE TO (b): Common cold. — 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Chronic Myocarditis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4-, 1956, to 8-7-, 1956, that I last saw the deceased alive on 8-7-, 1956, and that death occurred at 1205 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas R. Lee M.D. — ADDRESS (Street, city or town, state): Berlin Md — DATE SIGNED: 8-9-56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 8/10/56 — 22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN — 22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md — 24a. REC'D BY REGISTRAR DATE 8-10-56 — 24b. REGISTRAR'S SIGNATURE: Helen F Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8857

CERTIFICATE OF DEATH

68845

Reg. Dist. No. 357

1. PLACE OF DEATH

COUNTY: Worcester — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill, Md.

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill, Md.

STREET ADDRESS (If rural give location): 407 Covington, Street

3. NAME OF DECEASED (Type or Print): (First) Henrietta (Middle) G. (Last) Waters

4. DATE OF DEATH: (Month) August (Day) 7 (Year) 1956

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F.	C.	Widow	Jan. 24 1898	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Domestic	Maryland	U.S.A.

13. FATHER'S NAME: William Martin

14. MOTHER'S MAIDEN NAME: Catherine Corbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	201-07-1935	Gwynn Allen 407 Covington St. Snow Hill, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 IMMEDIATE CAUSE (A) Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1956, to Aug. 7, 1956, that I last saw the deceased alive on Aug. 7, 1956, and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE AND TITLE OF M.D.: Harold Eyre M.D. — ADDRESS (Street, city, town, state): Snow Hill Md — DATE SIGNED: 8/9/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/10/56	Tinsley Chapel Cem.	Pocomoke City, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS
Aug 9, 1956	Glenn E. Cooper	Edgar Wharton New Church, Va.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8846

8841

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 43 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 402 Laurel Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City,
d. STREET ADDRESS: 402 Laurel Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lloyd — Middle: H. — Last: Wessells

4. DATE OF DEATH: Month: August — Day: 22 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1867

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Wessells

14. MOTHER'S MAIDEN NAME: Laura Fenton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Purla Anna Wessells, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis multiple — INTERVAL BETWEEN ONSET AND DEATH: Several days.
DUE TO (b): Cerebral Arteriosclerosis + General
DUE TO (c): Aging process

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 ×

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia, mod to sod. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 July, 19 50, to August 22 19 56, that I last saw the deceased alive on 22 August, 19 56, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: N. E. Sartorius, Jr. M.D. — ADDRESS (Street, city or town, state): Pocomoke, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): N. E. Sartorius, Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-26-56

22c. NAME OF CEMETERY OR CREMATORY: Goodwill M.E. Cemetery

22d. LOCATION (City, town, or county) (State): Rural- Pocomoke, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR — DATE: 8/28/56

24b. REGISTRAR'S SIGNATURE: Anne White

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 202 8-27-56 et

8858

CERTIFICATE OF DEATH

18847

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
c. LENGTH OF STAY IN 1b 80 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle Wilmer Lost Whittington

4. DATE OF DEATH Month Aug. Day 19, Year 1956

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 29, 1875
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret)
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Berlin, Md (RFD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John R Whittington
14. MOTHER'S MAIDEN NAME Martha Emily Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Mrs. J.W. Whittington Berlin, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH

151X

DUE TO (b) Chr Nephritis — 3 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1956 to Aug 19, 1956 that I last saw the deceased alive on Aug 19, 1956, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Chas R. Law M.D. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 8-20-56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/22/56
22c. NAME OF CEMETERY OR CREMATORY Evergreen
22d. LOCATION (City, town, or county) Berlin (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE AUG 24 1956
24b. REGISTRAR'S SIGNATURE Helen F. Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55